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### 2024 Blue Cross and Blue Shield Service Benefit Plan - FEP Blue Focus Summary of Benefits for the Blue Cross and Blue Shield Service Benefit Plan FEP Blue Focus – 2024 Page 140

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### Summary of Benefits for the Blue Cross and Blue Shield Service Benefit Plan FEP Blue Focus – 2024

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**Do not rely on this chart alone.** This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure.

You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at [www.fepblue.org/brochure](http://www.fepblue.org/brochure).

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Below, an asterisk (\*) means the item is subject to the \$500 per person (\$1,000 per Self Plus One or Self and Family enrollment) calendar year deductible. If you use a Non-PPO physician, benefits are not provided.

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#### **Medical services provided by physicians, specialists and other healthcare**

**professionals:** Preventive, adult

**You pay:**

Preferred provider: Nothing

Non-preferred (Participating/Non-participating): You pay all charges

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#### **Medical services provided by physicians, specialists and other healthcare professionals:**

Preventive, child

**You pay:**

Preferred provider: Nothing

Non-preferred (Participating/Non-participating): You pay all charges

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**Medical services provided by physicians, specialists and other healthcare professionals:**

Professional Visits

**You pay:**

Preferred provider: \$10 for the first 10 visits per calendar year (combined medical and mental health and substance use disorder)

After the 10th visit: 30%\* of the Plan allowance (deductible applies)

Non-preferred (Participating/Non-participating): You pay all charges

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**Medical services provided by physicians, specialists and other healthcare professionals:** Diagnostic and treatment services provided in the office

**You pay:**

Preferred provider: 30%\* of the Plan allowance (deductible applies)

Non-preferred (Participating/Non-participating): You pay all charges

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**Medical services provided by physicians, specialists and other healthcare professionals:** Telehealth services

**You pay:**

Preferred Telehealth Provider: Nothing for the first 2 visits per calendar year

After the 2nd visit: \$10 copayment per visit

Non-preferred (Participating/Non-participating): You pay all charges

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**Services provided by a hospital:** Inpatient

**You pay:**

Preferred: 30%\* of the Plan allowance (deductible applies)

Non-preferred (Member/Non-member): You pay all charges

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**Services provided by a hospital:** Outpatient

**You pay:**

Preferred: 30%\* of the Plan allowance (deductible applies)

Non-preferred (Member/Non-member): You pay all charges

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